The Commonwealth of Massachusetts
Division of Professional Licensure

Board of Registration of Speech-Language Pathology and Audiology
239 Causeway Street, Boston MA 02114
(617) 727-3071
www.mass.gov/dpl/boards/sp

FORM 1 - SUPERVISED PROFESSIONAL PRACTICE PLAN

THIS PLAN MUST BE COMPLETED, SIGNED, AND RETURNED TO THE BOARD OFFICE WITHIN THIRTY (30) CALENDAR DAYS OF THE START OF YOUR SUPERVISED PROFESSIONAL PRACTICE TO BE CONSIDERED.

INSTRUCTIONS:
- **TYPE OR PRINT IN INK**
- **PLEASE READ CAREFULLY BEFORE COMPLETING**
- **ANSWER ALL QUESTIONS. WRITE "NOT APPLICABLE" IF NO OTHER RESPONSE IS APPROPRIATE**
- **USE ADDITIONAL PAGES IF NECESSARY**
- **IF SUPERVISOR CHANGES PLEASE SUBMIT A FORM II TO COMPLETE THAT PORTION OF THE CFY, NEW SUPERVISOR NEEDS TO SUBMIT A NEW FORM I/FORM II WHEN COMPLETED.**

TO BE COMPLETED BY APPLICANT

1. AREA OF LICENSURE ( )AUDIOLOGY ( )SPEECH-LANGUAGE PATHOLOGY

NAME:_____
(last) (first) (middle)
ADDRESS:_____
(number) (street)
_____
(city) (state) (zip code)

PHONE:_____ _____
(business) (home)

2. PROFESSIONAL PRACTICE RESPONSIBILITIES
List approximate number of hours per week to be spent in each activity.

ACTIVITIES/HOURS PER WEEK

A. Diagnostics_____
B. Therapy (totals)_____
1. language disorders_____
2. articulation disorders_____
3. voice disorders_____
4. fluency disorders_____
C. Aural Rehabilitation_____
D. Identification and Evaluation of Hearing Impairment_____
E. Record Keeping_____
F. Staff Meetings_____
G. In-Service Training_____
H. Other (explain)_____

3. PROFESSIONAL PRACTICE EMPLOYMENT INFORMATION **SPP PLAN 2**

A. Employer_____
(company name) **(division or department)**
Address_____
(number) **(street)**
_____
(city) **(state)** **(zip code)**

B. Beginning date of employment_____

C. Date Supervised Professional Practice to start_____

D. Date Supervised Professional Practice to end_____

E. Number of hours per week in: Audiology_____ **Speech-Language Pathology**_____

4. STATE OF THE APPLICANT

I HAVE DISCUSSED THE PLAN FOR SUPERVISION WITH THE PERSON NAMED BELOW AND AGREE TO ITS IMPLEMENTATION.

_____ _____
(applicant's signature) **(date)**

TO BE COMPLETED BY SUPERVISOR

NAME:_____
(last) **(first)** **(middle)**
ADDRESS:_____
(number) **(street)**
_____
(city) **(state)** **(zip code)**
PHONE:_____ _____ _____
(home) **(work)** **(cell)**
Email_____

5. CURRENT LICENSURE STATUS
Audiology_____ **Speech-Language Pathology**_____ **Both**_____

Massachusetts License #_____ **Expiration date**_____
Other state (specify)_____**License #**_____**Expiration date**_____

6. PROFESSIONAL CERTIFICATION:
ASHA/CCC_____**Membership #**_____**Expiration date**_____
AAA/ABA_____**Membership #**_____**Expiration date**_____
None_____

7. SUPERVISION
THE SUPERVISED PROFESSIONAL PRACTICE SUPERVISOR MUST BASE THE TOTAL EVALUATION ON NO LESS THAN 36 OCCASIONS OF MONITORING ACTIVITIES (A MINIMUM OF FOUR HOURS EACH MONTH). THESE MONITORING ACTIVITIES MUST INCLUDE AT LEAST 18 ON-SITE OBSERVATIONS (A MINIMUM OF TWO HOURS EACH MONTH).

SPP PLAN 3

METHODS	SESSIONS/MONTH	LENGTH/SESSION	ACTIVITY(see 2)
A. On site observations	_____	_____	_____
B. Remote observations	_____	_____	_____
(audio, video tape)	_____	_____	_____
C. Conferences (phone)	_____	_____	_____
D. Review of Records	_____	_____	_____
1. therapy plans	_____	_____	_____
2. diagnostic reports	_____	_____	_____
E. Staff Meetings	_____	_____	_____
F. Case Staffings	_____	_____	_____
(placement meetings)			

8. STATEMENT OF SUPERVISOR

I HEARBY CERTIFY THAT ALL STATEMENTS MADE BY ME IN RELATION TO THIS PLAN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF. I FURTHER CERTIFY THAT I UNDERSTAND THE RESPONSIBILITIES OF A SUPERVISOR AS STATED IN THE RULES AND REGULATIONS OF THE MASSACHUSETTS BOARD OF REGISTRATION FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY (260 CMR).

_____

(supervisor's signature) **(date)**